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7

8 **BEFORE THE**
9 **BOARD OF REGISTERED NURSING**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. **2010-367**

13 **VICTORIA SALANDANAN PIETRASZ**
6635 Topaz Street
14 Alta Loma, CA 91701

A C C U S A T I O N

15 Registered Nurse License No. 510500

16 Respondent.

17
18 Complainant alleges:

19 **PARTIES**

20 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her
21 official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department
22 of Consumer Affairs (Board).

23 2. On or about April 10, 1995, the Board issued Registered Nurse License No. 510500
24 to Victoria Salandanan Pietrasz (Respondent). The Registered Nurse License was in full force
25 and effect at all times relevant to the charges brought herein and will expire on December 31,
26 2010, unless renewed.

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1 Board of California, and the Board of Vocational Nursing and Psychiatric Technicians, to
2 encourage appropriate consistency in the implementation of this subdivision.

3 "The board shall seek to ensure that licentiates and others regulated by the board are
4 informed of the responsibility of licentiates to minimize the risk of transmission of blood borne
5 infectious diseases from health care provider to patient, from patient to patient, and from patient
6 to health care provider, and of the most recent scientifically recognized safeguards for minimizing
7 the risks of transmission."

8 6. Section 2764 provides, in pertinent part, that the expiration of a license shall not
9 deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or
10 to render a decision imposing discipline on the license. Under section 2811, subdivision (b), the
11 Board may renew an expired license at any time within eight years after the expiration.

12 REGULATORY PROVISIONS

13 7. California Code of Regulations, title 16, section 1442, states:

14 "As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from
15 the standard of care which, under similar circumstances, would have ordinarily been exercised by
16 a competent registered nurse. Such an extreme departure means the repeated failure to provide
17 nursing care as required or failure to provide care or to exercise ordinary precaution in a single
18 situation which the nurse knew, or should have known, could have jeopardized the client's health
19 or life."

20 8. California Code of Regulations, title 16, section 1443, states:

21 "As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the
22 failure to exercise that degree of learning, skill, care and experience ordinarily possessed and
23 exercised by a competent registered nurse as described in Section 1443.5."

24 9. California Code of Regulations, title 16, section 1443.5 states:

25 "A registered nurse shall be considered to be competent when he/she consistently
26 demonstrates the ability to transfer scientific knowledge from social, biological and physical
27 sciences in applying the nursing process, as follows:

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1 "(1) Formulates a nursing diagnosis through observation of the client's physical condition
2 and behavior, and through interpretation of information obtained from the client and others,
3 including the health team.

4 "(2) Formulates a care plan, in collaboration with the client, which ensures that direct and
5 indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and
6 for disease prevention and restorative measures.

7 "(3) Performs skills essential to the kind of nursing action to be taken, explains the health
8 treatment to the client and family and teaches the client and family how to care for the client's
9 health needs.

10 "(4) Delegates tasks to subordinates based on the legal scopes of practice of the
11 subordinates and on the preparation and capability needed in the tasks to be delegated, and
12 effectively supervises nursing care being given by subordinates.

13 "(5) Evaluates the effectiveness of the care plan through observation of the client's
14 physical condition and behavior, signs and symptoms of illness, and reactions to treatment and
15 through communication with the client and health team members, and modifies the plan as
16 needed.

17 "(6) Acts as the client's advocate, as circumstances require, by initiating action to improve
18 health care or to change decisions or activities which are against the interests or wishes of the
19 client, and by giving the client the opportunity to make informed decisions about health care
20 before it is provided."

21 10. California Code of Regulations, title 16, section 1444, states, in pertinent part:

22 "A conviction or act shall be considered to be substantially related to the qualifications,
23 functions or duties of a registered nurse if to a substantial degree it evidences the present or
24 potential unfitness of a registered nurse to practice in a manner consistent with the public health,
25 safety, or welfare. Such convictions or acts shall include but not be limited to the following:

26 "(a) Assaultive or abusive conduct including, but not limited to, those violations listed in
27 subdivision (d) of Penal Code Section 11160. . . ."

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1. **COST RECOVERY**

2. 11. Section 125.3 provides, in pertinent part, that the Board may request the
3. administrative law judge to direct a licensee found to have committed a violation or violations of
4. the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
5. enforcement of the case.

6. **FIRST CAUSE FOR DISCIPLINE**

7. **(Unprofessional Conduct)**

8. 12. Respondent is subject to disciplinary action under section 2761, subdivision (a) and /
9. or (d), in conjunction with California Code of Regulations, title 16, section 1444, in that from on
10. or about February 1, 2006, to on or about March 29, 2006, Respondent committed acts of
11. unprofessional conduct substantially related to the qualifications, functions or duties of a
12. registered nurse which to a substantial degree evidence her present or potential unfitness as a
13. registered nurse to practice in a manner consistent with the public health, safety, or welfare.
14. Respondent failed to demonstrate the necessary knowledge and skills required of a licensed
15. registered nurse to sustain employment as a licensed registered nurse for the Department of
16. Mental Health at Patton State Hospital, Patton, California (PSH).

17. 13. On or about February 1, 2006, Respondent accepted an employment position with the
18. title and duties of Registered Nurse at PSH. The Registered Nurse employment position required
19. Respondent to be licensed by the Board as a registered nurse, and to exercise that degree of
20. learning, skill, care and experience ordinarily possessed and exercised by a competent registered
21. nurse¹ by consistently demonstrating the ability to transfer scientific knowledge from social,
22. biological and physical sciences in applying the nursing process².

23. 14. From on or about February 1, 2006, through on or about March 29, 2006, Respondent
24. was employed at PSH in the position of Registered Nurse.

25. 15. In an adverse action, effective March 29, 2006, the California Department of Mental
26. Health, Patton State Hospital, issued a "Notice of Rejection During Probationary Period" against

27. ¹ (Cal. Code Regs., tit. 16, § 1443.)

28. ² (Cal. Code Regs., tit. 16, § 1443.5.)

1 Respondent rejecting her during her probationary period from her employment position of
2 Registered Nurse for "reasons relating to . . . [her] qualifications, the good of the service, or
3 failure to demonstrate merit, efficiency, fitness, and moral responsibility." Respondent's
4 "behavior as stated . . . demonstrates dishonesty and serious misconduct for a Registered Nurse in
5 that . . . [her] ability to apply basic nursing techniques is unacceptable." Respondent appealed.

6 16. On or about September 7, 2006, *In the Matter of the Appeal by Victoria Pietrasz*,
7 Case No. 06-0954, the California State Personnel Board issued a "Withdrawal of Appeal"
8 wherein Respondent's appeal was withdrawn and the adverse action was final.

9 17. The circumstances surrounding the adverse action rejecting employment of
10 Respondent during her probationary period are as follows:

11 a. On or between February 1, 2006, through February 28, 2006, Respondent completed
12 new employee training. PSH required all registered nurses to be certified in blood drawing prior
13 to performing blood draws on patients, an ordinary nursing procedure.

14 b. On or about March 13, 2006, for patient H.E., Respondent performed a blood draw
15 and failed to demonstrate ordinarily possessed registered nursing skills, as follows:

16 i. Respondent failed to thoroughly wash her hands prior to beginning to draw the
17 patient's blood;

18 ii. Respondent failed to collect necessary materials prior to beginning to draw the
19 patient's blood;

20 iii. Respondent failed to check proper blood draw sequencing for the blood tests
21 ordered;

22 iv. Respondent failed to verify the patient's identity for the blood draw;

23 v. Respondent failed to change needles between five (5) blood draw attempts on
24 the patient – poking the patient five (5) times with the same needle before completing a
25 successful blood draw; and

26 vi. Respondent failed to chart the blood draw in the patient's medical record.

27 c. On or about March 13, 2006, Respondent as the registered nurse on duty in the
28 Nurse's Station, in the presence of another unit's supervisor and a psychiatric technician,

1 disregarded a physician's request for assistance in a treatment room. Respondent failed to leave
2 the Nurse's Station and go to the treatment room to assist the physician. Respondent
3 acknowledged her duty to respond to the physician's request for aid when she called the physician
4 in the treatment room and falsely told him, "I'm in the Med Room, what to do you need?"

5 d. On or about March 14, 2006, for patient D.M., Respondent performed a blood draw
6 and failed to demonstrate ordinarily possessed registered nursing skills, as follows:

7 i. Respondent failed to change needles between multiple blood draw attempts in
8 the patient's left arm;

9 ii. Respondent failed to successfully draw blood in two (2) attempts. Respondent
10 attempted to draw blood on both of patient D.M.'s hands leaving three (3) different visible
11 puncture sites, and an additional seven (7) puncture marks on the patient's left antecubital³

12 iii. Respondent falsely charted in patient D.M.'s medical record when she
13 incorrectly documented the blood draw being from the patient's right antecubital when, in fact, it
14 was from patient D.M.'s left antecubital. In patient D.M.'s medical record, Respondent charted:

15 "Blood drawn for Patton panel, CBC, TSH from R) antecubital vein – good
16 blood return – tolerated well – specimen to Program 3 refrigerator ready for
17 pick-up. No swelling, hematoma nor complaint verbalized after specimen
18 drawn – awaiting results at this time."

19 e. On or about March 16, 2006, Respondent admitted that she was aware of PSH's
20 blood drawing policy and procedure wherein a nurse after making two (2) unsuccessful blood
21 draw attempts on a patient was to stop attempting to draw blood on a patient and request
22 assistance.

23 f. On or about March 16, 2006, for patient L.L., Respondent performed a blood draw
24 and failed to demonstrate ordinarily possessed registered nursing skills, as follows:

25 i. Respondent failed to confirm the identity of the patient prior to being reminded;

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28 ³ The antecubital region of the body is the front (or inside) of your elbow.

1 ii. Respondent failed to properly wash her hands before beginning a blood draw
2 on patient L.L. requiring another R.N. to demonstrate proper hand washing procedure;

3 iii. Respondent failed to wash her hands after completion of the blood draw
4 procedure prior to being reminded; and then, failed to properly wash her hands after the
5 procedure. Respondent lightly rinsed her hands instead of washing them; and

6 iv. Respondent failed to verify and confirm the doctor's order for the blood draw
7 without reminder.

8 g. On or about March 16, 2006, for patient P.S., Respondent performed a blood draw
9 and failed to demonstrate ordinarily possessed registered nursing skills, as follows:

10 i. Respondent failed to use a clean new tourniquet on patient P.S. for a blood
11 draw. Prior to being stopped, Respondent attempted to use patient L.L.'s used tourniquet soiled
12 with wet blood for patient P.S.'s blood draw;

13 ii. Respondent failed to perform a successful blood draw on patient P.S. by
14 inserting a sterile vacutainer⁴ needle into the hand of patient P.S., drew blood to the surface,
15 withdrew the needle and before being stopped, attempted to re-insert the contaminated vacutainer
16 needle into patient P.S.' hand for another attempt at a blood draw; and

17 iii. Respondent failed to perform a successful blood draw within two attempts,
18 when on the second blood draw attempt on patient P.S., Respondent inserted a sterile vacutainer
19 needle to the level of the vacutainer's hub deep into P.S.'s hand before failure.

20 h. On or about March 17, 2006, for patient V.N., Respondent failed to follow-up on the
21 patient's acute care hospital reports⁵. Respondent failed to perform an ordinary registered nursing
22 duty that allows informed health care decisions or activities to be improved or changed, timely,
23 for the patient.

24 ⁴ The Vacutainer™ system consists of a double-pointed needle, a plastic holder or adapter,
25 and a series of vacuum tubes with rubber stoppers of various colors. The colors of the rubber
26 stoppers on the vacuum tubes indicate the type of additive in the tube that mixes with the drawn
27 blood. The type of additive dictates the kind of blood test(s) the laboratory can perform on the
28 blood sample. The patient's blood flows directly into the appropriate test tube.

⁵ Acute care is short-term medical treatment, usually in a hospital, for patients having an
acute illness or injury or recovering from surgery. The hospital's goal is to discharge the patient
as soon as the patient is deemed healthy and stable, with appropriate discharge instructions.

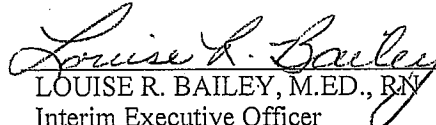
PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Registered Nurse License No. 510500, issued to Respondent;
2. Ordering Respondent to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to section 125.3;
3. Taking such other and further action as deemed necessary and proper.

DATED: _____

2/3/10


LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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